MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Vision Care

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Contents

New Vision Care Treatment Authorization Request (TAR) Process Effective July 1, 2006

Effective for vision care services performed on or after July 1, 2006, the *Payment Request For Vision Care and Appliances* (45-1) claim form will no longer be used to request prior authorization for medically necessary contact lenses, low vision aids and other non-Prison Industry Authority covered items.

Instead of the 45-1 claim form, providers will use the 50-3 *Treatment Authorization Request* (TAR) form to submit prior authorization requests for eye appliances services performed on or after July 1, 2006. A draft of this form is included with this bulletin.

The 50-3 TAR form is available and can be ordered by contacting the Telephone Service Center (TSC) at 1-800-541-5555. **However, the 50-3 TAR form cannot be used to request authorization for any service performed prior to July 1, 2006**. Please continue to follow current procedures using the 45-1 claim form to request prior authorization for dates of service prior to July 1, 2006.

New Authorization Process

The current authorization process requires that an original 45-1 claim form be mailed to the Vision Care Policy Unit (VCPU) for authorization. Effective for vision services performed on or afterJuly 1, 2006, the 50-3 TAR form and associated documentation can be mailed or faxed to:

California Department of Health Services
Vision Care Policy Unit
MS 4600
P.O. Box 997413
Sacramento, CA 95899-7413

VCPU Fax Number: (916) 552-9077

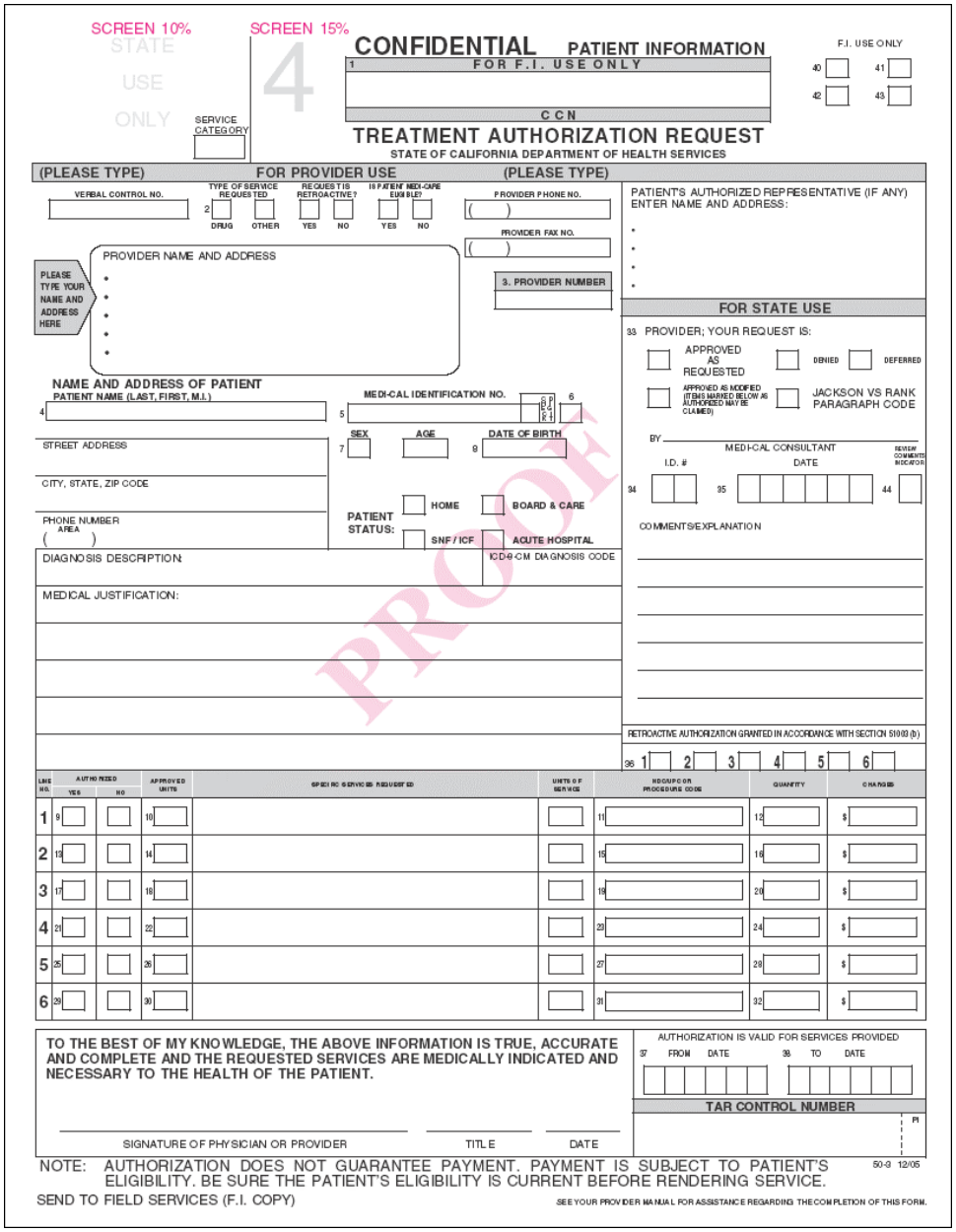
Providers should see an improved response and turnaround time for authorizations since the new TAR process allows faxed TAR submissions and responses.

Upon completion of the authorization review process, the VCPU will fax (if a valid fax number is included on the form) or mail the 50-3 TAR form back with a decision (Approved as Requested, Approved as Modified, or Denied or Deferred). All TARs are assigned a TAR Control Number (TCN) and Pricing Indicator (PI) on the 50-3 form. Claims for approved services must include a valid TCN and PI for payment. The assigned TCN and PI are also required for resubmission of deferred TARs.

Please see **TAR Process**, *page 2*

TAR Process *(continued)*

Specific instructions about how to use the 50-3 TAR form and how to submit claims of approved services for payment will be addressed at Medi-Cal instructor-led seminars and future *Medi-Cal Updates*. For a schedule of upcoming seminars, please call the TSC or visit the Medi-Cal Web site at **www.medi-cal.ca.gov** and click "Education and Outreach" and then "Medi-Cal Instructor-Led Seminars."


SCREEN 10% SCREEN 15%
STATE USE ONLY
SERVICE CATEGORY
4
CONFIDENTIAL PATIENT INFORMATION
FOR F.I. USE ONLY
CCN
F.I. USE ONLY
TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES
(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)
VERBAL CONTROL NO.
TYPE OF SERVICE REQUESTED DRUG OTHER
REQUEST IS RETROACTIVE? YES NO
IS PATIENT MEDI-CAL ELIGIBLE? YES NO
PROVIDER PHONE NO.
PROVIDER FAX NO.
PROVIDER NAME AND ADDRESS
PLEASE TYPE YOUR NAME AND ADDRESS HERE
3. PROVIDER NUMBER
PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:
FOR STATE USE
33. PROVIDER; YOUR REQUEST IS:
APPROVED AS REQUESTED
DENIED
DEFERRED
APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)
JACKSON VS RANK PARAGRAPH CODE
BY
MEDI-CAL CONSULTANT
I.D. #
DATE
REVIEW COMMENTS INDICATOR
COMMENTS/EXPLANATION
NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.)
MEDI-CAL IDENTIFICATION NO.
SUFFIX
SEX
AGE
DATE OF BIRTH
STREET ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER AREA
PATIENT STATUS: HOME BOARD & CARE SNF / ICF ACUTE HOSPITAL
DIAGNOSIS DESCRIPTION:
ICD-9-CM DIAGNOSIS CODE
MEDICAL JUSTIFICATION:
RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)
LINE NO. AUTHORIZED YES NO APPROVED UNITS SPECIFIC SERVICES REQUESTED UNITS OF SERVICE HCPCS OR PROCEDURE CODE QUANTITY CHARGES
1 2 3 4 5 6
TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.
SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE
AUTHORIZATION IS VALID FOR SERVICES PROVIDED
FROM DATE TO DATE
TAR CONTROL NUMBER
NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.
50-3 12/05
SEND TO FIELD SERVICES (F.I. COPY)
SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.
PROOF

New *Treatment Authorization Request* (50-3) Form

Exceptions to Submitting CIFs

Providers are reminded not to submit *Claims Inquiry Forms* (CIFs) for the following Remittance Advice Details (RAD) code messages, unless information on the CIF specifically addresses the denial reason. For example, if the denial was 002, but an error is found in the recipient ID on the original claim, this would be an appropriate CIF, with a changed recipient ID. However, if providers wish to challenge the determination, a CIF will result in the same denial. A review by a person in the appeals unit is the only way of resolving denials if the claim has a unique circumstance needing human intervention.

Code	Message
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.

The updated information is reflected on manual replacement page cif co 2 (Part 2).

CHDP 2006 Poverty Level Income Guidelines

The 2006 Federal Poverty Income Guidelines are effective April 1, 2006 through March 31, 2007. The guidelines are used to determine eligibility for the Child Health and Disability Prevention (CHDP) program. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following chart.

For additional CHDP information, call the Telephone Service Center (TSC) at 1-800-541-5555.

FEDERAL POVERTY INCOME GUIDELINES
200 Percent of Poverty by Family Size

Number of Persons	Gross Monthly Income	Gross Annual Income
1	$ 1,634	$ 19,600
2	$ 2,200	$ 26,400
3	$ 2,767	$ 33,200
4	$ 3,334	$ 40,000
5	$ 3,900	$ 46,800
6	$ 4,467	$ 53,600
7	$ 5,034	$ 60,400
8	$ 5,600	$ 67,200
9	$ 6,167	$ 74,000
10	$ 6,734	$ 80,800
For each additional person, add	$ 567	$ 6,800

CCS/GHPP SAR Exceptions Update

Effective for dates of service on or after April 1, 2006, California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) providers need a separate Service Authorization Request (SAR) for the following drugs, factors and nutritional products:

- Anti-Inhibitors (J7198)
- Factor VIIa Recombinant (Q0187)
- Minerals/Protein Replacements/Supplements
- Sildenafil
- Tadalafil
- Vardenafil
- Von Willebrand Factors (Q2022)

In addition, effective for dates of service on or after April 1, 2006, Factor VIIa Recombinant should be billed using HCPCS code Q0187. HCPCS code Z5230 will no longer be an active code.

This updated information is reflected on manual replacement page cal child sar 6 (Part 2).

Convert Early to HIPAA-Compliant Electronic Claim Transactions

Effective July 1, 2006, regardless of date of service, the Vision Computer Media Claims (CMC) proprietary format transaction will not be accepted for vision services. Additionally, the (Professional) Medical Data Specifications (part of the *837 Version 4010A1 Health Care Claim Companion Guide*) have been updated to include the required segments for vision claims for dates of service on or after July 1, 2006. The (Professional) Vision Data Specifications will no longer be valid as of July 1, 2006. The companion guides are available on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking "HIPAA" from the home page, then "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications."

To ensure that electronic vision claims are accepted by Medi-Cal beginning July 1, 2006, providers submitting electronic claims in formats other than the HIPAA-compliant ASC X12N 837 v.4010A1 transaction should begin conversion enrollment and approval activities immediately. Providers using outside vendors for billing should ensure that these vendors submit electronic claims in a HIPAA-compliant electronic format by the above date as well.

Enrollment and approval of HIPAA-compliant electronic claim submitters can take 30 days or more to complete. Therefore, providers are strongly encouraged to begin the transition immediately to be compliant prior to July 1, 2006. Regardless of the date of service, non-HIPAA compliant formats will not be accepted as of July 1, 2006.

To enroll, test and begin submitting electronic claims on the 837 transaction, call the Telephone Service Center (TSC) at the numbers listed below. Providers can request a Medi-Cal Now conference packet, which contains the following information:

- Telecommunications application and agreement
- Medi-Cal provider enrollment Frequently Asked Questions
- Requirements for submitting 837 version 4010A1 transactions
- Provider Relations Organization (PRO) TSC phone list and menu prompts
- CMC enrollment procedures and checklist
- 837 transaction Webcast CD

In addition, instructions for CMC submissions can be found on the Medi-Cal Web site by clicking the "CMC" link in the Provider Resources section on the home page.

Please see **Electronic Claim Transactions**, *page 5*

Electronic Claim Transactions *(continued)*

To further support your transition, Medi-Cal has implemented a self-service validation tool, the HIPAA Transaction Utility Tool. This tool is free and provides everything needed to exchange Electronic Data Interchange (EDI) files with Medi-Cal. This Web-based validation tool allows providers to test transaction compliance with Medi-Cal specifications. The tool also contains documentation such as EDI specifications (Companion Guides) in a format that can be browsed online or easily downloaded.

The HIPAA Transaction Utility Tool is accessed from the sysdev Medi-Cal Web site Transaction Services page (**http://sysdev.medi-cal.ca.gov**). We strongly encourage you to take advantage of this service.

- Click the "Transaction Login" link from the sysdev Medi-Cal home page.
- Enter your current Medi-Cal submitter ID and password. Your submitter ID must be prefixed with "CMCSUB" and the password is the same password you use for CMC dial-up access. Click "Submit."
- The "Transaction Services" menu will appear. Click the "HIPAA Transaction Utility Tool" link. A separate window will open for the application.
- After you have opened the Transaction Utility Tool application, you can click on the User Guide link located in the left navigation bar for step-by-step use and instruction.

For more information, in-state providers may call the TSC at 1-800-541-5555, from 8 a.m. to 5 p.m., Monday through Friday. Border providers, software vendors and out-of-state billers who bill for in-state providers should call (916) 636-1200. To learn more about other vision care-related HIPAA changes, refer to the "Vision Care Changes Coming Soon" link in the "HIPAA News" section of the Medi-Cal Web site.

Instructions for Manual Replacement Pages

Part 2

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Remove and replace:	cal child sar 5/6
Remove :	cif co 1 thru 10
Insert:	cif co 1 thru 11